

Hippa Consent Form
For
Frank Alexander DDS, PA

By signing below, you consent to use and disclosure of your protected health information by Frank Alexander DDS, PA, our staff, and our business associates for treatment, payment, and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices. You have the right to review our Notice prior to signing this consent. The terms of the notice may change. If it does, you may obtain a revised Notice by contacting this office. At 817 460-4712. We also post the Notice in the office.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment, healthcare operations, although we are not required to agree to the restrictions. If we do agree, they are binding on us. Finally, you may refuse to consent to use or disclosure of your information, but it must be in writing. Under this law, we have the right to refuse treatment should you refuse to disclose your Protected Health Information (PHI).

I have reviewed, understand and agree to the content of the Notice of Privacy.

Name _____ Date _____

Please specify the exact reason why patient chose not to sign.
